

Words

Dignity and medical procedures

Alexander McCall Smith, *Department of Civil Law, University of Edinburgh*

There is little lack of rhetoric on the subject of dignity. 'The dignity of the individual', 'freedom and dignity', 'the dignity of a natural death' - these expressions, and others, are familiar in political and ethical discussions. But what exactly does dignity imply? Surprisingly, it is a term which is rarely defined. Just as with cruelty or evil, we tend to recognise indignity when we are confronted by it, but such intuitive recognition is hardly sufficient for the purposes of the serious ethical debate which now surrounds the topic of the control of medical and scientific progress.

Two scholars from different disciplines have recently touched on the notion of human dignity. In an elegant essay, 'On Dignity', Aurel Kolnai has attempted to spotlight those attributes of behaviour which lead it to be described as dignified (1). Central to Kolnai's concept of dignity is the control which a person has over his actions. Undignified behaviour is behaviour in which passion of some sort is a predominant feature. We do not conduct ourselves with dignity if we allow ourselves to be 'overcome' with anger or other emotions, acting, as a result, in a way which is seen as inappropriate. A man hopelessly in love and quite incapable of doing anything but pursuing the object of his passion loses in this sense his dignity.

Looking at the problem from a different point of view, Leon Kass stresses that dignity is synonymous to an extent with 'excellence'. 'In all its meanings', suggests Kass, '(dignity) is not something which, like a navel or a nervous system, is to be expected or to be found in every living human being' (2). Indignity, on the other hand, is seen as an 'offence against personal dignity' (according to one dictionary definition of it). It is questionable whether Professor Kass is right to stress the 'excellent' or 'honourable' attributes of the notion of dignity, attributes which would be deemed to be present or absent in any one person according to objective criteria. Dignity can surely also be founded on a subjective notion of worth which is entertained by the person himself. Thus one who is devoid of excellence according to what is objectively seen as excellence, and who may also have little worth as an individual in the sense of

being of negative value to a community, may still have a sense of his own worth which constitutes his personal dignity. In this sense, indignity is an affront to an individual dignity which may be born by someone who, according to objective standards, may otherwise be considered to be lacking in dignity.

If there is then, at the least, a certain level of personal dignity which we may take to be present in every human being (except, arguably, in the case of one who has absolutely no sense of his own worth), in what way can this dignity be affronted by certain medical procedures? It is a common argument that we should abstain from subjecting a person suffering from a terminal illness to procedures which compromise dignity and merely prolong an existence that is rapidly becoming increasingly undignified. These procedures are certainly not intended as an affront and therefore cannot be said to infringe dignity deliberately, in the way in which an intentional insult may do. If they do pose a threat to dignity then, this threat must exist in certain ambivalent features of the procedures which, by virtue of the condition of the person upon whom they are visited, constitute an indignity.

The patient's willingness

Perhaps the most obvious feature of these procedures, as with most other medical procedures, is the fact that the physical integrity of the patient is invaded. *Prima facie*, however, we do not regard any interference with our physical integrity as compromising our dignity. An ordinary medical examination or even vigorous manipulation of a displaced limb may involve a fair degree of intrusiveness, and yet not be regarded as undignified. Clearly what distinguishes these procedures from similar actions which we would describe as assaults, and consequently ones which we would regard as an affront to dignity, is the consent which accompanies them. We consent to these procedures and they are therefore not performed against our will, but with our endorsement: they are what we *want*.

This suggests that there is in the concept of respect for dignity a requirement of the subject's willingness. Being subjected to a procedure against one's will appears undignified because of the fact that something is being imposed, and this offends the principle of self-determination. Dignity would, in many cases, seem to imply the making of a choice

after a considered assessment of the attractions or otherwise of a particular course of action. Since restrictions on freedom of choice, or the total removal of such freedom, may be seen as diminishing dignity, a medical procedure which is not consented to may be considered an obvious case of an affront to dignity.

This proposition is fairly straightforward, but there may be difficulties either in relation to certain forms of treatment to which consent is given, or in relation to varieties of consent which are interpreted as conferring legitimacy on invasions of integrity. The first of these cases involves procedures which are of such a nature that they may be described as inherently undignified by virtue of their extreme character. It would be possible to think of surgery so radical and extensive that even if fully consented to and therapeutic in aim, we might be inclined to describe it as an affront to dignity. In such circumstances, the description of a procedure as undignified need not necessarily mean that we feel tempted to decline or prohibit it, but the fact that it threatens the dignity of the patient might be taken as one element in a calculus of benefit/disadvantage. It may be that a therapeutic procedure involves such indignity that on balance it is decided not to recommend it to the patient. Of course, the value placed on the dignity factor in the assessment of the procedure's desirability is likely to be less than the value of such factors as improved health or relief from pain.

Non-therapeutic experimentation

Where dignity might be a more powerful consideration in this category would be when the procedure is part of a programme of non-therapeutic experimentation. Here there are strong grounds for arguing that major indignities, even if not physically harmful, should be viewed with caution by those concerned with assessing the ethical acceptability of the research in question. Submission to physically invasive procedures for non-therapeutic purposes inevitably involves viewing the subject as a means rather than an end, and this of course may be regarded as ethically suspect. In another, and persuasive view, however, it is possible to argue that participation in such procedures for altruistic motives works to negate any element of indignity which the physical invasion itself might entail. Discomfort, or even physical mutilation, might cease to appear an affront to dignity if it is seen as being undergone for a praiseworthy goal. The research subject who willingly accepts hardship and pain for the future benefit of humanity lends through these motives a dignity to his experiences which they might otherwise not possess.

It is perhaps in this notion of purpose or usefulness that the kernel of the notion of dignity in this context can be identified. If we consider the actions

of the research subject who volunteers to submit himself to what would normally be considered indignities (where, for example, he gives up his power of self-control and requires the assistance of others for simple movements), the ulterior objective of the procedures is seen as conferring dignity. Similarly, if a person submits to therapeutic procedures which involve an equivalent diminution of self-control, these may not be seen as undignified if they are clearly likely to lead to the restoration of health. A man under an anaesthetic might be subjected to gross physical intrusion during the course of an operation and yet this will not be seen as an affront to his dignity.

Prolongation of life

Clearly, though, there will be cases in which our view of the purpose of the procedures is such that we do not see them as justified. In such circumstances, when we can see no acceptable point to the application of the treatment, the immediate physical invasion, rather than the presumed reason for its application, comes into sharpest focus. If there can be no outcome to a particular condition other than death, then it seems inappropriate to subject the patient to any discomfort which cannot in itself promise ultimate amelioration of the condition. Therapy, as opposed to pain relieving treatment, thus cannot act as a justification in these circumstances.

It is for this reason that the prolongation of life can in itself be seen as an inherently undignified procedure where it involves the use of extreme measures which cannot possibly retrieve the patient from inevitable death. Here our viewing the situation as involving indignity is based on something more than the patient's loss of control over himself, it also entails a judgment of the pointlessness of the patient's suffering. Any invasion which the medical procedures involve is, in these circumstances, gratuitous, and therefore all the more insulting.

One of the alleged justifications for continuing treatment at all costs, even when there is no hope of ultimate recovery, is that this is to be assumed to be the wish of the patient, even if he is incapable of expressing it. Alternatively, individual doctors may argue that they are obliged to continue with treatment because it is their duty to do everything in their power to prolong life.

Both of these arguments have certain overtly objectionable features and can fairly be said to affront the dignity of the patient. As far as the first of these is concerned, the problem lies in the assumption that a prolonged life is what is always wanted. Here cultural factors are crucial. In some cultures, particularly in contemporary western societies, there is a tendency to refuse to face the facts of human imperfection and mortality, and as a consequence, a horror of death. Against this

background, the staving-off of bodily dissolution might be assumed to be the normal wish or expectation.

This view is partially a corollary of the contemporary tendency to assume that certain desiderata constitute a healthy norm for all. This has certainly been the case with questions both of physical and mental health, where the ideal of a physically healthy and mentally 'balanced' or 'integrated' person has been extensively absorbed into official policy. In such a climate, it may be seen as unusual for an individual to deviate from a commitment to the extension of the life span or the utilisation of the advanced medical techniques that have been developed for this purpose.

The second argument, the argument from the duty to save or prolong life, is objectionable in that it involves a compromise of the status of the patient as an end in himself. If the patient is viewed in this way, he becomes a cog in a relentless process, and is consequently deprived of a substantial part of his individual humanity.

Apart from cases in which dignity is considered in the context of life-prolonging treatment, there are also circumstances in which it is a consideration in decisions as to whether to undertake treatment at all or whether to recommend the termination of pregnancy. In these cases, reference is often made to the prospects which the patient or the fetus may have of living life with some dignity; dignity would seem here to be regarded as one of the features which lend worth to existence, almost a *sine qua non* of a satisfactory life.

Genetic screening and prediction

To clarify the significance of the concept in these cases, the analysis of typical examples might be useful. Looking first at the undertaking of treatment, this might arise where an infant is born with a severe deformity which is susceptible to surgical treatment but which cannot be completely alleviated. The most usual example of this sort of deformity would be spina bifida. If the case is very severe, the doctor is faced with the necessity of deciding whether to

operate and thus give the child perhaps a few years of life, or whether to refrain from undertaking treatment. If he does decide to provide treatment, then he will be conscious of the fact that the life led by the child would be a limited one, as well as being one of dependency. In saying that such a life will be one from which dignity is lacking, it is not only the dependence which we have in mind but the sense of inability to realise full potential.

Similarly, now that techniques of genetic screening and prediction make it possible for deformities to be detected prior to birth, the question of dignity can intrude into discussions of abortion. In this context, handicap may be seen as an indignity, and hence as one of the factors to be taken into account in any decision as to whether to recommend abortion. Even where there is no question of the fetus being abnormal, the notion of dignity is sometimes involved in the abortion debate as grounds for justifying abortion for social reasons. An excessively large family with its resultant material restrictions is, in this view, something which compromises the dignity of its individual members.

All of these cases would seem to demonstrate that there may be a tendency to equate dignity with perfection. To an extent, this is probably a result of the subtle shift which has taken place in the philosophical and political discussion of human rights over the last two decades. With the increased emphasis on the material aspect of human rights and the associated demotion of the idealistic element, there has been a tendency to ignore the inherent dignity of human intellectual and spiritual integrity. A concomitant of such a change in emphasis might well be a tendency to ignore the fact that dignity need not necessarily be compromised by deformity or hardship. In many cases, of course, a convincing case can be made out for saying quite the opposite.

References

- (1) Kolnai A. On Dignity. *Philosophy* 1976; 51: 251.
- (2) Kass L. Averting one's eyes or facing the music? - on dignity and death. In: *Death inside out*. New York: 1975; 101.